

Instructions for the Request for COVID Related Temporary Telework Form

An employee may submit a request to telework based upon criteria established by OPM and DAS (i.e. childcare issues, self-monitoring).

In order to fully complete the form, please be sure to:

1. Check off the reason for the request and include all required information (such as number and ages of children).
2. List the specific, tangible work you will complete while at home. This should include specific information, not just "write narratives" or "respond to calls."
3. List the electronic devices provided to you by DCF in the "Work to be performed" section.

By signing this form, you, the employee, attest that the information contained herein is true and accurate.

After completing the form, please give the signed form to your supervisor.

The supervisor should review the form to determine whether the employee has specified a reason for the telework request, has the electronic devices necessary to perform work from home, and has sufficient work to complete at home.

A supervisor may approve from one day to five days of telework each week, based on the ability of the employee to perform his or her duties from home.

This approval is for an initial term of two weeks and will expire on 3/27/2020.

Please submit all completed signed applications to Human Resources.

Department of Children of Families
Request for COVID Related Temporary Telework

Name: _____ **Office/Division/Bureau:** _____

Title: _____ **Function:** _____

Name and Title of Supervisor: _____

Reason for Request:

<input type="checkbox"/> Returning from a CDC designated Level 3 Country	<input type="checkbox"/> Contact with a person who had contact with a person directed to self-monitor by a medical provider or government official (name and title):
<input type="checkbox"/> Returning for a CDC designated Level 2 Country	
<input type="checkbox"/> Caring for sick family with COVID	
<input type="checkbox"/> Transportation disruptions	<input type="checkbox"/> Directed by a medical provider or government official to self-monitor (name and title):
<input type="checkbox"/> Medically compromised condition on record	
<input type="checkbox"/> Concerns about exposure in public settings	<input type="checkbox"/> Domicile with or had contact with a person directed to self-monitor by a medical provider or government official (name and title):
<input type="checkbox"/> Care of a Parent	
<input type="checkbox"/> Child Care (number and age of child(ren))	

Work to be performed:

Supervisor recommendation: ____ Yes ____ No

Reason if not recommending approval :

Supervisory Signature: _____

Date: _____

Program Supervisor recommendation (if applicable): ____ Yes ____ No

Reason if not recommending approval:

Supervisory Signature: _____

Date: _____

Director Approval ____ Yes ____ No

Reason if not recommending approval:

Supervisory Signature: _____

Date: _____